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ABSTRACT

Interest in the family is pervasive throughout American culture today. The problematic relationship between the family and modern society is recognized by those of diverse political persuasions. Contemporary interest in the family is not entirely problem-oriented, however. Within the past 2 decades a quiet undercurrent of research focusing on families that are doing well has generated a substantial movement to strengthen American families. The primary motivation behind the pioneer research on strong, healthy families has been the realization of a compelling need for a non-pathological understanding of families. Two research traditions have contributed to present knowledge of strong, healthy families: "family strengths" research, and "healthy family" or "normal family" research. Both research traditions have largely developed in parallel relation to each other. As an aid to family professionals and policymakers whose decisions affect families, this paper presents a summary review of six pioneer research projects that have made major contributions to knowledge of strong, healthy families. The researchers include Herbert Otto; Robert Hill; Stinnett and colleagues; Kantor and Lehr; Lewis, Beavers and the Timberlawn Team; and Olson and McCubbin and Associates. The stated purpose of the review is to provide a concise record of the research itself in order to make it more accessible to interested professionals and policymakers. (LLL)

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A Family Research Study

Pioneer Research on Strong, Healthy Families

by
Elizabeth A. Morgan

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Elizabeth A. Morgan

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I. Introduction

Interest in the family is pervasive throughout American culture today. The problematic relationship between the family and modern society is recognized by those of diverse political persuasions. That the family must now be defended as a viable social institution is obvious from the titles of several influential books published within the last decade: Lasch's *Heaven in a Heartless World: The Family Besieged* (1977), Keniston's *All Our Children: The American Family Under Pressure* (1977), Abbott's *The Family on Trial* (1982), Kramer's *In Defense of the Family* (1983), and Berger and Berger's *The War Over the Family* (1983).

Contemporary interest in the family is not entirely problem-oriented, however. Within the past two decades a quiet undercurrent of research focusing on "families that are doing well" has generated a substantial movement to strengthen American families. The primary motivation behind the pioneer research on strong, healthy families has been the realization of a compelling need for a non-pathological understanding of families.

Two research traditions have contributed to present knowledge of strong, healthy families—"family strengths" research, and "healthy family" or "normal family" research. Both research traditions have largely developed in parallel relation to each other. Nick Stinnett, a leading researcher in the area of family strengths, articulated the need for knowledge of strong, healthy families in these terms:

> *Admittedly we need information about the problems, but we also need a balanced view. We need more information about positive family models and what strong families are like. We need to learn how to strengthen families. We don't learn to do anything looking only at how it shouldn't be done. We learn most effectively by examining how to do something correctly and studying a positive model. We have not had this positive model as much as we need in the area of family life.* (1979a: 23; 1979b: 5).

Mental health professionals working directly with problem families recognized the contribution research on strong, healthy families could make to their practice. Froma Walsh, editor of *Normal Family Processes* (1982) and family therapist, argues that

> *assumptions about normal families explicitly and implicitly influence clinical assessment, treatment goals, therapeutic approaches, and research instruments. Where knowledge about normal family processes is limited, inferences tend to be derived from pathology-based models, prevalent social norms, and personal family experience. Moreover, concepts of "normality" and "health" are often confounded, and myths of the "normal family" abound* (1982: xiii).

As an aid to family professionals and policy-makers whose decisions affect families, this paper presents a summary review of six pioneer research projects that have made major contributions to knowledge of strong, healthy families. Because the strong, healthy family research to be reviewed was done by professionals from a variety of disciplines, this research serves as some example of the kind of diversity and "ecology of disciplines" which make up the family field (see Burr and Leigh, 1982). The purpose of the review is to provide concise record of the research itself—rationale, design, sample, methodology, findings, etc.—in order to make it more accessible to interested professionals and policymakers. Critical evaluation and integration of these six very different approaches to the study of strong, healthy families is considered beyond the scope of this paper.

The primary motivation behind pioneer research on strong, healthy families has been the realization of a compelling need for a non-pathological understanding of families.

"We don't learn to do anything looking only at how it shouldn't be done. We learn most effectively by examining how to do something correctly and studying a positive model."

II. "Family Strengths" Research

A. Herbert Otto

The first pioneer in family strengths research was Herbert Otto. Otto's family strengths research began in 1959 while he was director of a "Mental Health Education" program at the University of Georgia. The preventive and experimental focus of the University of Georgia program combined with Otto's theoretical interest in the human potential movement shaped his approach to family strengths (Otto, 1964a: 439). To Otto, the decision to research family strengths was

clarified in these terms:

> *One of the most persistent questions confronting public health-mental health programmes has been: Should we continue to concentrate vast resources on the so-called problem families . . . and individuals in various stages of pathology or disorganization? Or, on the other hand, can we devise a preventive programme of working with families or individuals in such a way as to foster and further develop the essential healthiness which is already present?* (Otto, 1962b: 185)

Otto moved to the University of Utah's Graduate School of Social Work in 1960 where he directed the Family and Personal Resource Development Projects (Otto, 1962b). Otto's research on family strengths at the University of Utah was presented in a number of articles. In 1964, he and John Gabler published the first review of literature focusing on family strengths entitled, "Conceptualization of 'Family Strengths' in Family Life and Other Professional Literature" (Gabler and Otto, 1964). Otto's work on family strengths continued as part of the "Human Potentialities Project" at the University of Utah until he left in 1967 to co-found the National Center for the Exploration of Human Potential in San Diego, California (Otto, 1974: 261).

Survey and evaluation research methodologies were employed in Otto's Family Resource Development Project at the University of Utah. Otto formulated three exploratory research questions to guide his work:

1. What are individual and family strengths?
2. How do we help individuals and families recognize and utilize their strengths and resources more fully?
3. How do we work with strengths?
   (from Otto, 1962a: 77; 1963: 330–331)

Initially, a pilot survey of 27 families was conducted utilizing a Family Strengths Questionnaire. This questionnaire simply requested couples to complete the open-ended statement "The following are what we consider to be major strengths in our family: _ " (Otto, 1962a: 78; 1963: 331; 1966: 21). Couples filled out the questionnaire after discussing with each other what they considered to be their family strengths.

Evaluation research was done in Otto's small group work with families over time. A Family Resource Development Program was designed for a small group of married couples who would meet "for a series of twelve sessions for the purpose of focusing on family strengths" (Otto, 1963: 331). Group size was limited to twenty participants and length of group meetings was limited to two hours (Otto, 1964b: 144). Weekly attendance tended to be "uniformly about 80 percent with emergencies and illness accounting for the small number of absences" (Otto, 1963: 332). Activity during group meetings centered on identifying, developing, and discovering family and individual strengths (Otto, 1962b: 188; 1963: 332). "Action Programmes" were designed and implemented by participants themselves as an external means for developing family strengths in everyday life; reports and suggestions on "Action Programmes" were incorporated into weekly group meetings (Otto, 1962b: 188; 1963: 332; 1964b: 144). In these research-oriented Family Resource Development Program groups, one professional (often Otto) served as group leader while another professional observed the group (Otto, 1963: 187).

Data on family strengths was gathered from participants in the Family Resource Development Program in several ways. During the first session, two instruments were completed by couples together: the open-ended Family Strengths Questionnaire and a Family Strengths Inquiry. This Family Strengths Inquiry required couples to indicate whether any of sixteen family strengths areas would strengthen their family "(1) little, (2) some, (3) much" (Otto, 1962b: 186–187). Also, an Elias Family Opinion Survey was used in the first session. Responded to individually, this instrument was "a projective type test designed to measure 'feelings of hominess or homelessness' of an individual towards his intra-family relations" (Otto, 1962b: 188). During the final session of the program, the Family Strengths Questionnaire, Elias Family Opinion Survey, and a detailed evaluation questionnaire were completed by all group participants. Finally, group process data was collected in its entire audio form—"all sessions were tape-recorded and, following each group experience, an observer-leader conference was tape-recorded" (Otto, 1962b: 188).

The sample used in Otto's family strengths research included the 27 pilot survey families, two additional groups of families who were surveyed (Otto, 1963: 331) and "over a dozen different groups of families participating in the Family Resource Development Program" (Otto, 1975: 2–3). Much of Otto's family strengths sample was made up of volunteer families involved in churches. All 27 families completing the pilot survey were "church affiliated" (Otto, 1966b: 21). Many Family Resource Development Programs were conducted "under church auspices" (Otto 1975: 2).

Some sample characteristics of Family Resource Development Program participants were reported by Otto (see 1962b, 1963, 1964a, 1975). Age of couples

ranged from mid-twenties to mid-sixties. Couples also varied in terms of age of children and whether children were still living at home; at least one couple had no children. A number of participating family members had college backgrounds while others had only completed high school. All families were initially viewed as "healthy, well-functioning, non-patient" families.

Analysis of findings from Otto's "family strengths" research resulted in perhaps the earliest information on family strengths obtained from families themselves and a framework of specific family strengths.

Analysis of the Family Strengths Questionnaire completed by 27 families in the pilot survey showed some of the commonality and diversity of family strengths among families in quantitative terms. Results are found in Otto 1962b; 1966b. Otto reported in 1963 that "this pilot study was subsequently repeated with two other groups of families and similar results obtained" (p. 331). What strengths the pilot survey families listed and how many of the 27 families listed each strength are presented below (from Otto, 1962a: 78; 1966b: 22):

Analysis of findings from Otto's "family strengths" research resulted in the earliest information on family strengths obtained from families themselves . . .

Family Strength	No. of Families
a. Shared faith, religious and moral values	22
b. Love, consideration and understanding	17
c. Common interests, goals and purpose	15
d. Love and happiness of children	13
e. Working and playing together	10
f. Sharing specific recreational activities	10
g. Being in accord on discipline	5
h. Respect for individuality of family members	5
i. Shared sense of humor	4
j. Enjoying companionship	4
k. Good health	4
l. Desire for learning and education	4
m. Miscellaneous (less than 4 families per item on 34 different items)	

Otto pointed out in his 1966 presentation of the pilot survey that "shared faith, religious and moral values," "affective elements of family life" (indicated by items 2 and 4), and "doing things together as a family" (suggested by items 5 and 6) appeared to be major sources of family strength (p.22).

Otto's framework of family strengths was developed from pilot survey data and evaluation data from Family Resource Development Programs. Otto noted in 1963 "that the framework of family strengths as developed in the original pilot project (see 1962a) was modified and changed but not fundamentally altered as a result of the subsequent studies" (p. 331). Thus the similarity of Otto's 1975 framework of family strengths to the frameworks developed in his earlier analyses is not surprising. Otto's several analyses of family strengths identified the following items as essential to a framework of family strengths:

1. The ability to provide for the physical, emotional, and spiritual needs of a family.
2. The ability to communicate effectively.
3. The ability to provide support, security and encouragement.
4. The ability to initiate and maintain growth-producing relationships and experiences within and without the family.
5. The capacity to maintain and create constructive and responsible community relationships in the neighborhood, the school, town, local and state governments.
6. The ability to grow with and through children.
7. An ability for self-help, and the ability to accept help when appropriate.
8. An ability to perform family roles flexibly.
9. Mutual respect for the individuality of family members.
10. A concern for family unity, loyalty, and interfamily cooperation. (from Otto, 1962a; 1963; 1975a)
11. The ability to be sensitive to the needs of the family members. (from Otto, 1962a; 1963)
12. The ability to use a crisis or seemingly injurious experience as a means of growth. (from Otto, 1963; 1975a)
13. The ability to "give and take" in the area of child rearing practices and discipline. (from Otto, 1975a)

B. Robert Hill

Robert B. Hill's analysis of *The Strengths of Black Families* (1971) was stimulated by Otto's pioneer work on family strengths. The pathological perspective of black American family life characterizing academic and policy discussion in the 1960's (e.g., Hill refers to Glazer and Moynihan, 1965) was rooted in concern with the problems of a few black families. Hill points out that

Unfortunately, this traditional focus has created the false impression that instability and pathology are characteristic of most black families. There is a tendency to forget that deviance, by definition, refers to departures from the norm. Thus, in general, deviance among blacks is as "abnormal" as it is among whites. The great majority of black families, for example, are not characterized by criminality, delinquency, drug addiction, or desertion (p. 1).

While Hill, Director of the Research Department of the National Urban League, was not the first scholar to develop a non-pathological view of black families, he was the first scholar attempting to operationally define black family strengths and to subsequently provide systematic empirical verification. (p.2).

The informal adoption rate of children born out-of-wedlock was also considerably higher among black families than white families.

The framework Hill uses for analyzing black family strengths is derived from both Parsons' view of the family as a social system (Parsons, 1951; Parsons and Bales, 1955) and Otto's (1962) identification of family strengths. Hill operationally defines family strengths as "those traits which facilitate the ability of the family to meet the needs of its members and the demands made upon it by systems outside the family unit. They are necessary for the survival and maintenance of effective family networks" (p. 3). A review of literature on black families in concert with the list of family strengths in Otto (1962) provided the basis for Hill's focus on five major black family strengths—those strengths that "have been functional for their survival, development, and stability:

1. Strong kinship bonds
2. Strong work orientation
3. Adaptability of family roles
4. Strong achievement orientation
5. Strong religious orientation"
   (Hill, 1971: 4)

Evidence for each of these black family strengths, manifested sometimes in unique forms, is presented by Hill (1971) from black family literature and from statistical data recorded in the 1970 national census and other major sources. (A summary of the statistical evidence is given in a set of twenty tables prepared by the Research Department of the National Urban League and included on pp. 41–55 of Hill's 1971 report.)

"Strong kinship bonds" were shown by black families taking more children not their own (under 18 years) into their household than white families, whether these were husband-wife or female-headed black families. Almost half (48 percent) of elderly black women over 65 reported children not their own living with them. (See Table 1, p. 41). The informal adoption rate of children born out-of-wedlock was also considerably higher among black families than white families (pp. 6–8).

A "strong work orientation" among black families, both poor and middle-income, was reflected in several ways. In about 90 percent of all husband-wife black families, husbands worked more and contributed more to family income than their wives (Tables 9, 10, p. 46). Figures from the Bureau of Labor Statistics in 1969 showed that "contrary to popular belief, the earnings of wives in low-income black families constitute a small proportion of the total family income. In only 15 percent of the black families with incomes under $3,000 did the wife's earnings equal or exceed the husband's" (p. 13; see Table 10, p. 46). Also relevant to strong work orientation in black families was data on poor female-headed black families which showed that 50 percent of these women worked at least part-time and that only 50 percent of all female-headed black families depended on welfare assistance (Tables 7, 8, p. 45).

"About 75 percent of black males and about 90 percent of the black women—regardless of status—indicated that their college attendance was influenced by their parents."

Empirical data relevant to "adaptability of family roles" as a black family strength indicate that "egalitarian" rather than "matriarchal" characterizes family role patterns among black families (pp. 18–20). Hill (1971) also noted that family role functioning among single-parent (usually father absent) black families was not found to be significantly different than that of comparable single-parent white families in Geismar and Gerhart's (1968) longitudinal study of 500 urban black, white, and Puerto-Rican families. The notion that black men abdicate family responsibilities primarily through desertion could not be supported from National Center for Social Statistics data on reasons for father absence given by female heads of black families on AFDC — "in only one fifth of the black AFDC families was the status of the father

characterized as 'deserted'" (p. 25; see Tables 13 and 14, pp. 49–50).

Indications of a "high achievement orientation" among black families were found in 1970 census data on the educational aspirations of black students. For instance, while "three-fourths of the blacks enrolled in college come from homes in which the family heads had no college education" (p. 30; see Table 17, p. 53), black students reported that their parents had high expectations of them to attend college. "About 75 percent of black males and about 90 percent of the black women—regardless of status—indicated that their college attendance was influenced by their parents" (p. 31; see Table 18, p. 54). Parental influence appeared to account for high educational aspirations among elementary school children from working-class black families: "While 64 percent of the white students said that their parents wanted them to finish college, a significantly higher proportion (80 percent) of the black students said that their parents wanted them to finish college" (p. 31, Hill citing Hindelang, 1970). In addition, occupational aspirations of high school students from low-status black families have been found to be higher than those of students from low-status white families—whether the families were intact or broken, rural or urban, (p. 31; Table 19, p. 54; Hill citing Cosby, 1971).

Family strengths were defined as those "relationship patterns, social and psychological characteristics which create a sense of positive family identity, promote satisfying interaction among family members, and encourage the development of individual potential of family members."

The "strong religious orientation" of black families still needs to be empirically documented, but Hill (1971) notes that the role of religion in shaping black American history is fairly common knowledge. A summary of the role of religion in emancipation and civil rights is presented by Hill:

> *Blacks have been adept at using religion as a mechanism for survival and advancement throughout their history in America. During slavery, religion served as a stimulant for hundreds of rebellions that took place. It was also a major source of strength during the civil rights movement of the 50's and the 60's (p. 33).*

C. Stinnett and Colleagues

The "Family Strengths" research initiated by Nick Stinnett and colleagues at Oklahoma State University in the mid-1970's developed out of recognition of accumulating evidence linking social and psychological problems with unsatisfying family life as well as awareness of the deeply held desires of most people for a satisfying family life (Stinnett and Sauer, 1977:3). With Kathryn Sauer, Stinnett (1977) endeavored to supplement Otto's 1960s contribution to understanding family strengths with more recent and extensive knowledge "concerning what, specifically, contributes to strong marital and parent-child relationships" (p. 3). Stinnett and Sauer's 1977 research on Oklahoma families became the first phase of the Family Strengths Research Project which has to date involved a great number of colleagues in the study of 3,000 strong families throughout the nation and world (Stinnett and DeFrain, 1985).

Stinnett and colleagues drew upon Otto's interpretation of family strengths to structure their research. Family strengths were defined, on the basis of Otto's (1975a) discussion, as those relationship patterns, social and psychological characteristics which create a sense of positive family identity, promote satisfying interaction among family members, and encourage the development of individual potential of family members (Stinnett and Sauer, 1977: 5). A primary purpose of the Family Strengths Research Project was subsequently expressed as an effort to examine the relationship patterns among strong families (Stinnett and Sauer, 1977: 5).

Survey research methodology was chosen by Stinnett and colleagues to obtain descriptive knowledge of strong families. A survey instrument, the Family Strengths Inventory, was developed as a major research tool for the Family Strengths Research Project. (A concise review of this instrument is found in Stinnett and DeFrain, 1985: 8–13, 184–187). The Family Strengths Inventory was "a questionnaire having both open-ended and fixed alternative-type questions. The questions included were based upon what a review of the professional literature suggested might be related to family success or strength" (p. 184).

The Family Strengths Inventory was submitted to a panel of family professionals who evaluated it according to criteria of relevance, clarity, and comprehensiveness; the Family Strengths Inventory was also pretested on a small group of families. The original Family Strengths Inventory contained more than a hundred questions on how . . . (a) family

functioned" (p. 11). Once national and international studies had documented a number of characteristics common to strong families, the Family Strengths Inventory was shortened and revised. Stinnett and DeFrain reported in 1986 that all 3,000 families studied in the Family Strengths Research Project "were surveyed with a questionnaire. Ten percent of these 3,000 families were also interviewed" (pp. 185–186).

The Family Strengths Research project of Stinnett and colleagues was carried out through a number of independent studies of strong families. The two major studies referred to most frequently by Stinnett and colleagues in describing their "family strengths" research are the Oklahoma study (reported in Stinnett and Sauer, 1977; Stinnett, 1979a, 1979b, 1983; Stinnett and DeFrain, 1986) and the first national study of strong families (reported in Stinnett, Sanders, and DeFrain, 1981; Stinnett, Sanders, DeFrain, and Parkhurst, 1982; Stinnett, 1983; Stinnett and DeFrain, 1985). These two studies provided not only a large data base for investigating various aspects of family strengths but also stimulated research on different types of families living in the United States and other countries (Stinnett and DeFrain, 1985; Lin, 1982, 1986).

The sample in the Oklahoma study of the Family Strengths Research Project was selected through the state Cooperative Extension Home economists from all 77 Oklahoma counties (see Stinnett and Sauer, 1977; Stinnett, 1979a, 5; 1979b, 12; 1983, 29–30; Stinnett and DeFrain, 1985, 8–10, 186). The home economists were asked to recommend families in their county whom they perceived as "strong" within the requirements of the Oklahoma study: appear to be happy, fulfill each other's needs, intact with both parents at home, at least one child 21 years or younger living at home.

Based on the home economists' recommendations, questionnaires "were sent to approximately 180 families. Questionnaires were included for both husband and wife. They were requested to complete the questionnaire separately and not to compare answers" (Stinnett and Sauer, 1977: 6). Only those families who rated themselves high on degree of marital happiness and parent-child satisfaction were included in the final sample. Final sample size for the Oklahoma study was 130 families. "The families were diverse in terms of socioeconomic status, race, ethnic origin, religion, and education. They came from urban and rural areas" (Stinnett and DeFrain, 1986: 10).

Analysis of findings from the Family Strengths Research Project in Oklahoma by Stinnett and colleagues eventually led to the distillation of six characteristics of strong families. In 1977, Stinnett and Sauer reported on responses to fifteen open-ended questions in the Family Strengths Inventory from 99 strong families (157 husbands and wives). The fifteen open-ended questions (see pp. 6-7) focused on marital and parent-child relationships, enhancement of self-esteem, communication, handling conflict, and dealing with the modern "fragmentation and fast pace of life" (p. 5). Stinnett and Sauer (1977) descriptively categorized and analyzed responses to the open-ended questions by means of percentages and frequency distributions (p. 6). Four characteristics or strengths emerged from Stinnett and Sauer's (1977) analysis as generally descriptive of these strong families: "(a) expression of appreciation to each other, (b) willingness to spend time together and participate in activities together, (c) good communication patterns, and (d) commitment to a religious life style" (p. 9).

From their analysis, Stinnett and colleagues concluded that six characteristics seemed to account for the success, happiness, and strength of these families:

1. Appreciation
2. Spending time together
3. Good communication patterns
4. Commitment
5. High degree of religious orientation
6. Ability to deal with crises in a positive manner.

In 1979, Stinnett presented the major results from the Oklahoma study of strong families. Analysis of the 130 strong families participating in the study had been extensive:

> *"Using information from the Family Strengths Inventory plus additional information from follow-up questionnaires and interviews . . . (Stinnett and colleagues) looked at demographic characteristics of strong families, communication in these strong families, how they spent their time, marital need satisfaction, life philosophies, personality characteristics of strong families, power structure, parent-child relationships, family commitment, relationship patterns, how they dealt with conflict, how they dealt with crisis, religious orientation, and vital-total marital relationships among strong families"* (Stinnett and DeFrain, 1986: 10).

From their analysis, Stinnett and colleagues concluded that six characteristics seemed to account for the success, happiness, and strength of these Oklahoma families:

1. Appreciation
2. Spending Time Together
3. Good Communication Patterns
4. Commitment
5. High Degree of Religious Orientation
6. Ability to Deal with Crises in a Positive Manner (Stinnett, 1979a; 1979b)

After moving to the University of Nebraska-Lincoln, Stinnett and colleagues at the University of Nebraska launched the first national study of the Family Strengths Research Project utilizing a volunteer (rather than a recommended) sample of strong families. A volunteer sample was selected by means of a one-time news release which described the study and requested families who perceived themselves as strong to contact the research team as volunteer subjects. A total of 48 newspapers in twenty-five states, representing every region in the United States, ran the news release (see Stinnett and DeFrain, 1985: 31-32). Stinnett and colleagues acknowledged that "the philosophy behind this approach is the old adage about needles. In short, we believed that rather than use a professional drawing from a strong family pool, we would let families make the decision themselves" (Stinnett, Sanders, and DeFrain, 1981: 34; Stinnett, 1983: 29). Stinnett and colleagues reported a "tremendous" response by families to the news release. Families who responded were sent copies of the Family Strengths Inventory (a copy for each husband and wife). Many families returning questionnaires "also sent elaborate stories describing their family and its characteristics and activities in detail" (Stinnett, Sanders, and DeFrain, 1981: 34; Stinnett, 1983: 29). The final sample size of 350 families was determined not only by number of questionnaires returned, but also whether families rated themselves high on degrees of marital happiness and parent-child satisfaction (Stinnett, 1983: 29; Stinnett and DeFrain, 1986: 186).

Two different analyses of "family strengths" were done during the course of the first national study of the Family Strengths Research Project. Early reports on the national study (Stinnett, Sanders, and DeFrain, 1981; Stinnett, Sanders, DeFrain, and Parkhurst, 1982) presented an analysis of "families who perceived themselves as strong" by examining a subsample of 283 families—the first 283 families who completed and returned Family Strengths Inventories. Later reports on the national study (Stinnett, 1983; Stinnett and DeFrain, 1986) refer to major results of the analysis of "strong families" in the final sample of 350 families.

Characteristics of the subsample of 283 "families who perceived themselves as strong" are detailed in Stinnett, Sanders, and DeFrain (1981: 35); and Stinnett, Sanders, DeFrain, and Parkhurst (1982: 17). These 283 volunteer families were two-adult families living in 25 states representing all regions of the country. The 283 families were 98.6% white; 85.4% were church members; 66% considered themselves religious or very religious; 79.9% of family income came from salaries and commissions; 53.4% of husbands held professional positions; 62.8% of wives described their occupation as homemaker; length of marriage to present spouse averaged 19.4 years; number of children per family averaged 2.9. Differences concerning age, educational achievement, and religious affiliation were also reported.

The analysis of the subsample of "families who perceived themselves as strong," focused on husbands' and wives' perceptions of their family relationships from the Family Strengths Inventory, which included questions to the subsample families regarding husbands' and wives' descriptions

> of their family, describing [a] family member, describing parent-child relationships, [and] describing relationships in family strengths activities: strong families engage in together, what strong family members do to make one another feel good about self, and what makes family communication patterns good or bad" (Stinnett, Sanders, and DeFrain, 1981: 34; see also Stinnett, Sanders, DeFrain, and Parkhurst, 1982: 16–17).

Stinnett and colleagues' subsample analysis utilized descriptive statistical strategies such as frequencies and percentages (Stinnett, Sanders, DeFrain, and Parkhurst, 1982: 17).

Three findings from the subsample of "families who perceived themselves as strong" are emphasized by Stinnett and colleagues—degree of happiness and closeness in family relationships, most important family strength, and major activity which contributed to making their family strong (Stinnett, Sanders, and DeFrain, 1981: 35). A summary of Stinnett and colleagues' statistical analysis of these indicators of strong family life are presented in Figure A (adapted from Stinnett, Sanders, DeFrain, and Parkhurst, 1982: 18).

The early reports of the first national study of the Family Strengths Research Project documented that the overwhelming majority of "families who perceive

themselves as strong" were indeed "strong families" according to Stinnett and colleagues' criteria of high degree of marital happiness and parent-child satisfaction. The early analysis of data from Stinnett and colleagues' national study suggested also that family strengths were identical to those factors perceived as strengthening husband-wife and parent-child relationships (Stinnett, Sanders, DeFrain, and Parkhurst, 1982: 20). Stinnett and colleagues concluded from their study of "families who perceive themselves as strong" that

> *the important characteristic which repeatedly emerged in describing these strong families across the nation were (a) love, (b) commitment, (c) communication, (d) religion, (e) understanding, (f) doing things together, (g) complimenting/appreciating, (h) building ego support, (i) trust, and (j) individuality. The most outstanding activity these families engaged in was enjoying the outdoors together* (Stinnett, Sanders, DeFrain, and Parkhurst, 1982: 21).

Figure 9.

Degree of Closeness and Happiness in Family Relationships

Variable	% Answering High or Very High
Closeness to Children	98
Closeness to Spouse	97
Happiness with Marriage	
Perception of Self	95
Perception of Spouse	95
Happiness with Children	
Perception of Self	99
Perception of Spouse	99

Most Important Family Strength	% of Respondents
Love	14.2
Religion	10.9
Respect	9.8
Communication	9.1
Individuality	9.0
Doing Things Together	8.2
Consideration of Others	7.3
Commitment	5.9

Most Important Family Strengthening Activity	% of Respondents
Enjoying Outdoors Together	12.5
Vacations	10.3
Church	9.6
Sports	8.6
Eating Together	8.6
Cultural and Intellectual Interests	5.6
Games	5.1
Community Involvement	5.1

Analysis of data from the final sample of 350 strong families who volunteered to participate in the first national study of the Family Strengths Research Project revealed the same six major characteristics of strong families studied in Oklahoma:

1. Appreciation
2. Spending time together
3. Commitment
4. Good communication patterns
5. High degree of religious orientation
6. Ability to deal with crises in a positive manner (Stinnett, 1983: 30–35)

The Oklahoma and first national studies of Stinnett and colleagues' Family Strengths Research Project provided not only a large raw data base for investigating various aspects of family strengths but also stimulated research on different types of families living in the United States and other countries (Stinnett and DeFrain, 1986: 10–13, 192–196). Also, the Oklahoma and first national studies of "family strengths" laid groundwork for Stinnett and colleagues to design similar studies which linked "family strengths" to other issues confronting families. Two examples are the Oklahoma study of "How Strong Families Cope with Crisis" (Stinnett, Carter, DeFrain, and Chesser, 1985) and the national study of "Personal Problems and Family Strengths" (Stinnett, Chesser, DeFrain, Knaub, and Hemmings, 1986).

The Family Strengths Research Project of Stinnett and colleagues now includes studies of strong single-parent families (Stinnett, 1988; Fricke, 1992), strong remarried families (Knaub, Haines, and Stinnett, 1984), strong executive families (Smith, 1983; Stinnett, Smith, Tucker, and Shed, 1985), strong black families (King, 1980), strong Russian emigrant families (Porter, 1981; Porter, Stinnett, Lee, Williams, and Townley, 1985), strong Latin American families (Casas, 1979; Casas, Stinnett, DeFrain, Williams, and Lee, 1984), strong Austrian, German, and Swiss families (Stoll, 1984), and strong black families in Soweto, Johannesburg, South Africa (Weber, 1984). After studying these and other strong families through the Family Strengths Research Project, Stinnett and colleagues observed that

> *one of the most amazing things about the research is that six qualities were mentioned time and time again in our contact with these families. Not every family mentioned all six qualities, of course, but the pattern became apparent very quickly* (Stinnett and DeFrain, 1986: 14).

The six characteristics shared by the 3,000 strong families researched by Stinnett and colleagues are the six characteristics discovered in the original Oklahoma

and national studies of the Family Strengths Research Project (Stinnett and DeFrain, 1986: 14).

III. "Healthy Family" or "Normal Family" Research

The influence of general systems theory in the social sciences has served to transform much theory and practice dealing with human pathology from an atomistic individualistic perspective to a holistic systemic perspective. As a result, an increasing number of clinical professionals have come to view individual pathology in terms of family pathology. The reality of human needs encountered in a therapeutic setting helped foster this rather dramatic shift:

> *It was practical considerations and social events, not theoretical interests, that led to the questioning of traditional assumptions about the nature of psychotherapy. Many clinicians were discouraged with the results of individual therapy. Moreover, they did not think that their patients' psychopathologies were sufficiently clarified by the reductionistic and deterministic theories favored by medical and psychoanalytic thinkers* (Miller and Sobelman, 1985: 15).

The newly emerging professionals concerned with "family dysfunction," such as "family therapists" and "family psychiatrists," gradually began to seek more direct knowledge of families who were not dysfunctional or, more positively, families who were "healthy" or "normal." The underlying issue to be explored in the new research on "healthy families" or "normal families" was perhaps articulated by Barnhill (1978): "With much agreement that the family can be a unit of phychopathology, the question occurs, can it also be a unit of mental health?" (p.94)

The following description of pioneer "healthy family" or "normal family" research by Kantor and Lehr (1975), Lewis, Beavers, and the Timberlawn Team (1976), and Olson and McCubbin, and Associates (1983), will emphasize each group's research rather than their theoretical model. Those interested in an ongoing collegial exchange and theoretical developments related to this research are referred to such articles as Constantine (1983), Beavers and Voeller (1983), and Olson, Sprenkle, and Russell (1983).

A. Kantor and Lehr

A major effort to challenge the predominantly pathological perspective held by family therapists and researchers was launched by David Kantor and William Lehr at the Cambridge Family Institute in Boston, Massachussets. Kantor and Lehr's research project, begun in 1965 as "A Study in Vivo of Disturbed and Normal Family Milieux," is the primary basis for their often cited book, *Inside the Family: Towards a Theory of Family Process* (1975). While much of *Inside the Family* is a presentation of family theory, Kantor and Lehr (1975) made a significant contribution to research literature on "normal families" by studying the everyday life of both "normal" and "disturbed" families.

Kantor and Lehr (1975) designed "a naturalistic study of family life" in order to discover "the way in which families work" (p. xiii). Several factors were influential in shaping the design of Kantor and Lehr's (1975) research. 1) Kantor and Lehr (1975) thought family pathology would be more realistically understood if recognized as "extraordinary family phenomena" even for "disturbed" families:

> *Although we do not wish to deny their importance, we believe that disabling processes occupy a considerably smaller subclass in the universe of family events than the literature of family pathology might lead us to believe. As a result,* Inside the Family *concerns itself with the basic issues confronting all families as families. It seems to us that if a theory or model of family behavior is to be viable, it must be applicable to "healthy" or "normal" family processes as well as to pathological ones (p. ix).*

2) Though committed to systems theory assumptions, Kantor and Lehr (1975) found that systems literature had not answered an important question about family systems: "A system of what?"(p. x, xxi) 3) Finally, Kantor and Lehr (1975) were convinced that the "commonplace events" which made up every family's daily life—"that is, the dynamics and interactions that take place in familiar and comfortable surroundings, the myriad small events that occur from moment to moment in the lives of all families" (p. 2)—could best be understood by researchers going to the "natural geographic and social context" of a family's household environment (pp. 2–3).

A "clinical" methodology with an "emphasis on observation rather than on scientific measurement" (p. 3) was used by Kantor and Lehr (1975) in their naturalistic study. Kantor and Lehr (1975) sought a comprehensive understanding of families, including their "family phenomenology: . . . what it really felt like to live in a particular family" (p. 2), by collecting five different kinds of data (p. 3) summarized as follows. 1) Live-in participant observers reported on a number of family features: play, laughter, response to trouble, goals, expressions of affection, allocation of tasks, solidarity, dependence and independence, maintenance of family and kinship ties, and

designation of authority and responsibility (pp. 3–4). 2) Microphones were "placed in all rooms of a household to record the verbal communications that took place among members of a family during waking hours" (p. 4). 3) Research team staff conducted three sets of interviews—with each family as a whole, with subgroups in each family, and, halfway through the study, with each member of a family (pp. 4–5). 4) T.A.T. tests completed by all family members and 5) voluntary self-reports by family members were added to the research record. All data were transcribed in as complete a verbal form as possible.

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A sample comprised of 19 urban and suburban Boston area families was selected for Kantor and Lehr's study. The sample size of 19 families corresponded to a practical research goal of Kantor and Lehr's: "to study a limited number of families in as much detail as possible" (p. 2). Nine families included a diagnosed schizophrenic child and ten families were chosen that qualified as "normal" because mental health problems requiring hospitalization were absent. A range of social and demographic characteristics were represented in Kantor and Lehr's (1975) sample. "The families were roughly matched according to class, ethnic background, family composition, and neighborhood. An attempt was made to study public-housing and working-class families as well as middle-class and more affluent households" (pp. 1–2). Kantor and Lehr (1975) acknowledged two "informal" samples which provided them with observational data on family processes—Kantor and Lehr's families of origin and clinical families seen by Kantor, a family therapist (p. xi).

The descriptive content analysis of family process data done by Kantor and Lehr (1975) was both empirical or "operational" and theoretical (pp. xiii, 21, xiv-xv). Kantor and Lehr (1975) found that the task of analyzing naturalistic family data warranted a methodological conclusion significantly related to their goal of identifying elements of family process:

> *What did seem evident was that life inside the family, where we were witnessing it, did not conform to the descriptions of family behavior that had evolved from secondary contexts such as doctors' offices and individual interviews . . .*
>
> *This posed a major problem for us, for we had to observe phenomena in one context and try to give expression to them with borrowed concepts that had been developed in contexts we knew did not directly apply. We very soon learned that new conceptual tools would have to be developed if we were truly to comprehend the import of events that were happening before us in the households we were investigating"* (Kantor and Lehr, 1975: 5).

In relation to the substantive elements of Kantor and Lehr's (1975) data analysis task, concepts from systems theory and observations from naturalistic and clinical settings contributed to clarification (p. 22).

The empirical elements of family processes which Kantor and Lehr (1975) identified (singled out here from their theoretical presentation) provided some answer to Kantor and Lehr's question about family systems: "A system of what?"

The family system itself was observed by Kantor and Lehr (1975) to be "composed of three subsystems that interact with each other as well as with the world outside: these are the family unit subsystem, the interpersonal subsystem, and the personal subsystem" (p. 23). Kantor and Lehr (1975) emphasized that because the ongoing relations between these three subsystems all vary within families, "the formulation of conclusions about the whole based on the examination of a few parts can be hazardous" (p. 23); in other words, all three subsystems need to be studied together to obtain an adequate understanding of the family as a whole. Guided by a systems theory assumption that all systems are purposive, Kantor and Lehr (1975) referred to the empirical manifestations of goal-oriented dynamic activity and interactions in families as "strategies" (pp. 15–21). In the families they viewed, Kantor and Lehr (1975) found that the strategies used by any or all family subsystems to achieve their goals may be either cooperative or competitive, and that well-intentioned strategies "often produce unforeseen and/or unintended results" (pp. 31–35).

Six physical and conceptual dimensions of family processes (acts, interactions, strategies) were differentiated by Kantor and Lehr (1975) in their analysis. The three physical dimensions of family process—space, time, and energy—are the quantifiable means through which members' need for safety and participation are realized (p. 36). The three conceptual dimensions of family process—affect, power, and meaning—are the qualitative means through which members' need for specific life goals are thematically actualized (p. 36). According to Kantor and Lehr's (1975) analysis, the interrelationships among these six dimensions of family activity "constitute the framework in which the totality of family process takes place" (p. 37).

Kantor and Lehr (1975) further analyzed the differences between physical and conceptual dimensions of family processes as a difference of means and ends. To adapt a means-end distinction to an understanding of family process, Kantor and Lehr (1975) designated space, time, and energy as "access dimensions" of family process, while affect, power, and meaning were designated as "target dimensions" of family process (p. 37). Kantor and Lehr (1975) interpreted that

> *if space, time and energy are the media of family process, affect, power and meaning are the end points that are sought—that is, the targets of such process. Obviously these three targets are of a different conceptual and experiential order than the access dimensions. For one thing, no scales of measurement exist that enable us to quantify them* (p. 45).

In light of their research question, "A system of what?," Kantor and Lehr (1975) had observed that the family system involved several complex means-ends relationships.

The summary presented below of Kantor and Lehr's (1975) six dimensions of family process indicated some of the empirical elements Kantor and Lehr associated with each dimension (from pp. 37–52).

SIX DIMENSIONS OF FAMILY PROCESS

Space
- Interior Space
- Exterior Space

Time
- Clock Time
- Calendar Time

Energy
- Accumulation of Energy
- Expending of Energy

Affect
- **Affirmative Intimacy**—"a condition of mutual emotional closeness, often intense closeness, among peers" (p. 47)
- **Nurturance**—"an exchange in which one or more family members receive emotional support and encouragement from another member or members" (p. 47)
- Suggested measurable dynamic—degree of "joining and separating"

Power
- **[Exercise of Human Will]**—"transactions relating to voluntary or conative powers and faculties, that is, to matters of individual, conceptual, and intersocial volition" (p. 48)
- **Constructive efficacy**—"the ability to effect what the system wants, to get done what it wants to get done . . . Learning, exercising, and striving for a mastery of skills are all part of a family's efforts to be effective" (p. 49)
- Suggested measurable dynamic—degree of "freedom or restraint"

Meaning
- **Philosophical Framework**—that which "provides us with explanations of reality and helps us define our identity—so that we glean a sense of who and what we are" (p. 37)
- **Purposeful Identity**—"For an individual, to have an identity means to have an integrated sense of direction, and awareness of who one is and what one would like to become. It is the antithesis of uncertainty, confusion, or disorientation. Like individuals, families strive to develop identities, usually by emphasizing the unity and solidarity of members in a common cause or purpose and the existence of a meaningful "we" (p. 51).
- **[Understanding about the Family and its Worlds]**—
- elements of understanding the "social, spiritual, conceptual, material" worlds of the family include "ideas, credos, values, ideologies, world views, and a sense of good and bad and right and wrong" (pp. 50, 51).
- Suggested measurable dynamic—degree of shared and unshared meaning

These basic elements of family process were common to both "normal" and "disturbed" families in Kantor and Lehr's study. "Normal families," however, were observed by Kantor and Lehr as those families characterized by "patterns of family enablement" (pp. 231–232). On an empirical or

operational level "the term enabling refers to those strategies which facilitate a family's pursuit of its target ideals, and disabling to the patterns associated with a system's failure to attain its targets" (p. 163).

B. Lewis, Beavers and the Timberlawn Team

In the late 1960's, another major study of "healthy or normal families" was begun by a research team based at the Timberlawn Foundation in Dallas, Texas—Jerry M. Lewis, W. Robert Beavers, John T. Gossett, and Virginia Austin Phillips. Their research, reported in *No Single Thread: Psychological Health in Family Systems* (1975), exemplifies the shift among clinical professionals from an individual to a family orientation in treating mental and emotional health problems.

The Timberlawn team's "healthy family" research originated from Lewis and Gossett's 1966 involvement in reorganizing the inpatient adolescent service of Timberlawn Psychiatric hospital. Lewis and Gossett's work led to a research effort that attempted to measure critical aspects of family functioning as one of 3 variables related to the success or failure of adolescent functioning after hospital treatment for severe psychopathology (pp. 15–16).

The Timberlawn team's "healthy or normal family" research was carried out in two stages—a pilot study of 23 families (begun in the summer of 1968, p. 17) and a final study of 33 families. Methodologically, the Timberlawn team designed their research to focus on family interactional variables that might overcome the limitations of sociopsychological approaches which usually constructed a composite picture of the family from data based on individual observations or self-reports (pp. xvii, 5–8). The Timberlawn team indicated, however, that the sociopsychological research reported in Westley and Epstein's *Silent Majority: Families of Emotionally Healthy College Students* (1969), a project conducted from 1955 to 1964, had been "particularly stimulating for our research group" (Lewis, Beavers, Gossett, and Phillips, 1976: 6). It should be noted here that the "McMaster Model of Family Functioning" (Epstein, Bishop, and Levin, 1978; Epstein, Bishop, and Baldwin, (1982) traces back empirically to Westley and Epstein (1969). In their review of interactional studies on disturbed families, the Timberlawn team found that "such interactional measures were not only predictors of considerable strength, but also quantifiable methods of comparing and contrasting a wide spectrum of families" (p. 2).

The pilot study sample consisted of 12 "patient" families and 11 "nonpatient" families. Each of the 12 patient families contained a mid-adolescent child who was consecutively admitted as an adolescent inpatient in a psychiatric hospital; these families "were told to come for the family testing as a routine part of the treatment team's evaluation of their recently admitted adolescent" (p. 25). A group of 11 "nonpatient" families—defined as such because "no member of the family was currently receiving any form of psychiatric treatment nor in difficulty with legal authorities" (p. 26)—was selected as a control group for the pilot study. The "nonpatient" families were selected from a "large, local Protestant church" as "volunteers who responded to the urging of the church staff and in an informal talk by a member or the research team explaining the need for systematic data about healthy families" (p. 25). "Patient" and "nonpatient" families in the pilot sample were demographically comparable. Expectations of the two subsamples, however, were different: "nonpatient" families expected to be examined for "signs of health" while "patient" families expected "to be examined for information that would help the treatment team understand their youngster's psychopathology" (p. 43).

All "family interactional testing" took place at the Timberlawn Foundation, adjacent to the Timberlawn Psychiatric Hospital. Each family was informed of the research purposes of the testing and background information was obtained from each family member on role performance, the presence of symptoms of emotional origin, and whether the testing day was a typical day in the life of the family (p. 27). Prior to the family interactional testing, two "paper and pencil tasks" were completed by each family member: 1) an open-ended response to the question "What are the main problems in your family?" and 2) a 5-point scale rating of their family on 20 "Family Characteristics" —15 psychological or emotional, 5 economic characteristics (p. 27). Subsequently, videotaping of five 10-minute "family interactional tasks" was begun. The five "family interactional tasks" completed by the 23 pilot sample families involved:

1. "Main Problems"—discussion about the main problems of their family based on their responses to the "Main Problems" pencil and paper task.
2. "Planning Something Together"—the activity planned needed to be realistic for their family and require at least an hour to complete.
3. "Marital Testing"—(for parents only) evaluating and discussing self and spouse's happiest stage in their marital relationship.

4. "Family Closeness"— discussion of "what closeness means in our family" after each member privately responded to a "Closeness Board."
5. "Family Strengths"—discussion on "what is strong about our family," based of responses to the "Family Characteristics" pencil and paper task.

The videotaped "family interactional task" data from the pilot sample was evaluated by 12 raters (10 clinical professionals and 2 lay persons). Two raters working independently were assigned to evaluate each family interactional task. Raters did not know which families belonged to the "patient" and "nonpatient" subsamples and the viewing order of the 23 families was randomized for each pair of raters. All raters evaluated the videotaped segments they viewed on a common global measure of family health pathology—a 10-point "Family Health-Pathology Rating Scale" whereby families could be assessed on a continuum ranging from extremely healthy to extremely pathological (p. 32).

Pilot study findings on the Timberlawn team's "healthy family" research showed high inter-rater reliability concerning degree of health in the 23 pilot sample families (pp. 32–33), "patient" and "nonpatient" families were distinguished as two mutually exclusive groups (pp. 33–35), marital evaluations correlated significantly with whole-family evaluations (p. 35), evaluations based on 10-minute and 50-minute segments of family interaction correlated positively and significantly (p. 39), and family members' judgments of the strengths and weaknesses in their own family were in reasonable agreement with the mental health professionals' ratings (p. 42).

The second stage of the Timberlawn "healthy family" research project actually developed from the research team's direct encounter with the "nonpatient" or control group families participating in the pilot study: "It was from the opportunity to see the group of families judged by raters to be most healthy that the interest of the research staff in the interactional study of healthy family systems originated" (p. 17). As a result, the final study included only "healthy" or "nonpatient" families in the research sample. The final study was also marked by an interest in utilizing the systems theory framework developed by Beavers (see Chapter III) in evaluating healthy family data.

The sample of "healthy" families for the final study was retained from the same local Protestant church which provided the "nonpatient" control group families for the pilot study. A total of 137 families who contained an adolescent and were not perceived by the church staff as having significant problems were invited to participate in the final study. The Timberlawn research team met with these families to explain the study and the commitment involved on their part in completing the research. From the families who volunteered to participate, 33 families fulfilled three requirements of the final study sample: "1) biological intactness of the family, 2) oldest child in mid-adolescence, and 3) no family member in psychological difficulty for the past year as manifested by a self-acknowledged psychiatric syndrome, having received any psychological treatment, or being in legal difficulty" (p. 19).

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Data gathered on the 33 families in the final study was similar to that of the pilot study. All 33 families came to the Timberlawn Foundation and participated in "a family interview covering the current life situation of the family members, an extensive medical history, and a videotaping of their responses to the five Family Interactional Tasks" (p. 19). The Family Interactional Tasks for the final study had been modified and reordered. "Threatened Loss," an open-ended audio video of the imminent death of a family member, was substituted for the "Main Problems" family interactional task. The family interactional tasks were completed in the following order: 1) "Family Strengths," 2) "Threatened Loss," 3) "Marital Testing," 4) "Family Closeness," and 5) "Planning Something Together" (pp. 43–44).

Initial evaluation of final study data acquired

through videotaping the family interactional tasks utilized two types of rating scales. First, all 33 families were rated on the global measure used in the pilot study—the 10-point "Family Health-Pathology Scale;" this rating was done by four psychiatrists who worked independently and then rank-ordered the 33 families based on their ratings.

Second, all 33 families were assessed on a series of rating scales developed from Beavers' family systems model (see Chapter III) which outlined distinctions between "healthy," "mid-range," and "severely disturbed" family systems on five variables "considered important in the development of capable, adaptive, healthy individuals: 1) power, 2) the degree of family individuation, 3) acceptance of separation and loss, 4) perception of reality, and 5) affect" (p. 51). The Timberlawn research team then translated Beavers' family systems framework into a series of 13 rating scales.

"The Beavers-Timberlawn Evaluation Scales," represented a specific effort to measure family health and pathology in terms of the five variables cited by Beavers—power structure/style of leadership, parental coalitions, closeness of family members, congruency of family mythology with reality, efficiency of task negotiation and problem-solving, clarity of self-disclosure, responsibility for one's actions, invasiveness, permeability/openness to others, expressiveness, feeling tone, conflict, empathy (pp. 84–91). Reliability testing of the 13 "Beavers-Timberlawn Evaluation Scales" on raters within the Timberlawn research group and raters who were professionals outside of the research group showed that training in the use of the scales and clinical or research experience with families affected scores on inter-rater reliability (pp. 91–92). Rating of the five family interactional tasks of the 33 families on the "Beavers-Timberlawn Evaluation Scales" was conducted in the context of a "control group" of "70 families of hospitalized adolescents" (p. 92). The two groups of families were rated separately by one rater; "each of these raters had demonstrated significant interrater reliability with a third rater, a Registered Nurse graduate student, who had scored sub-samples of those two populations" (p. 92).

A correlational analysis of the two types of rating scale evaluations showed

> *significant correlation for each of the Beavers-Timberlawn Family Evaluation Scales and the Global Family Health-Pathology Scale. The high correlation of the sum of the 13 scales with a measure of global family health-pathology supported the hypothesis that most of the relevant dimensions implicitly used by the clinical raters were included in the 13 scales. (p. 92).*

With the exception of a .30 and a .52 correlation, correlation of the 13 scales with the global scale ranged from .60 to .79; correlation of the sum of the subscales with the global scale was .90 (Table 4–2, p. 93; $p < .005$).

The correlational analysis also indicated that, despite variations later discovered in the group of 33 healthy families (see Chapter V), differences in the means between the "healthy" and "control or patient" family groups on the "Beavers-Timberlawn Family Evaluation Scales" were significant with few exceptions (see Table 4–5, p. 96). The Timberlawn researchers thus concluded that "healthy families" appeared to differ from "patient families" on many variables rather than a single variable:

> *Healthy families were more likely to demonstrate a structure of shared leadership—tending toward (but not achieving) equalitarianism. The parental coalition was clear. Closeness was obvious. In their self-appraisal, such families were decidedly more congruent with an outside judgment. They demonstrated skill in effective negotiation; were clear in their expressions of feelings and thoughts; accepted responsibility for their actions; demonstrated little in the way of invasiveness; were openly expressive, and reasonably permeable to each other. Healthy families tended to be warmer, more optimistic, and reasonably emphatic with each other. There were low levels of conflict in such families (pp. 97–98).*

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More intensive clinical investigations of "healthy families" was conducted by selecting a subsample of 12 families from the 33 families in the final sample; the subsample included the six highest—and six lowest-ranking families on the global "Family Health-Pathology Scale."

Clinical observation data on these 12 families was generated from interviews by two family therapists. Each therapist saw each of the 12 families for two 90-minute interviews. The therapists were instructed to learn as much as possible about each family whereupon "both chose to rely upon fairly standard, verbal, exploratory interviewing techniques" (p. 99). All interviews were videotaped, thus providing for clinical observation six hours of family interaction data on each of the 12 families.

A clinical observer responded to the 72 hours of videotaped family interviews by dictating continuous commentary on the family interaction observed.

The Timberlawn researchers thus concluded that "healthy families" appeared to differ from "patient families" on many variables rather than a single variable.

Transcription of the clinical observer's commentary facilitated summarizing observations of each family's interactions in their interview with the therapist. The clinical observer's summary comments on individual family members, two-person interactions, and the family as a whole were then "assigned a positive, negative, or neutral valence. The valences represented a judgment regarding the power of the observed behavior either to further or to detract from human capabilities (p. 100)."

Evaluation of the clinical observation data on the subsample of 12 "healthy" families became the basis for the Timberlawn team's differentiation between "optimally functioning" and "adequately functioning" families on eight continuous variables. Descriptions of these eight variables are presented below in the order of their importance:

1) Affiliative versus oppositional attitudes towards others.
2) Respect for the unique experience and views of self and others versus disregard for the unique in self and others.
3) Open and direct communication versus distancing, obscuring, or confusing communication.
4) A firm parental coalition that is not challenged by a parent-child coalition versus a weak parental coalition in competition with a parent-child coalition.
5) An understanding of the complexity and variety of human motivation and needs is used in dealing with others versus a rigid, control-orientation in dealing with others.
6) Spontaneous interpersonal interaction patterns versus repetitive and stereotyped interaction patterns.
7) Initiative and an active-constructive orientation towards the outside world versus a passive orientation towards the outside world.
8) Individual family member characteristics that are unique, responsive, and creative versus individual characteristics that are bland or "plain vanilla."
(pp. 100–104)

Several other methodological approaches were used in the Timberlawn team's assessment of the 12 families in the subsample. 1) Microanalytic techniques developed by Riskin and Faunce (1970) to assess family communication interaction resulted in a rank-ordering of the 12 families in terms of health that correlated highly with other methods of rank-ordering used in the Timberlawn study (pp. 147–150, 201–202). 2) Individual interviews complemented data gathered in the family interviews which indicated differences between optimally and adequately functioning families (pp. 171–178,203). 3) Exploratory assessment of the relation between family interaction stimulated by a death and dying situation and the onset of physical illness showed a positive correlation between a family's psychological and physical health which, however, was not statistically significant (pp. 191–196, 204).

In an overview of their "healthy family" research, the Timberlawn team emphasized the characteristics distinguishing the most healthy or "optimally functioning" families identified in their final study sample. The most healthy families were found to demonstrate the most positive expressions of the eight descriptive characteristics identified in the clinical observation analysis with one exception—expression of initiative was equally positive for both optimally and adequately functioning families.

Interviews of family members in optimally and adequately functioning families revealed some striking differences between husbands and wives, though not children, in these two subgroups of healthy families:

The fathers from the families rated as optimal were more inclined to focus on interpersonal vocational satisfactions, and to be more directly supportive of their wives. Fathers from families rated as adequate were equally successful in providing for the family's economic needs, but appeared to focus less on interpersonal satisfactions. They were less supportive of their wives and although complementary, their comments suggested greater interpersonal distance. Although almost all the wives were involved primarily in the home, those from families designated as optimal expressed far greater degrees of marital and family satisfaction. The wives from adequate families were the most pained of any individuals in this sample. They clearly verbalized disappointment and frustration in their roles; had frequent psychophysiologic symptoms; were more often obese; and, in general, appeared to fulfill the stereotype of the disappointed, depressed, upper-middle-class housewife.

The children from these two groups of families were more alike than different. With rare exception, they appeared psychologically healthy; i.e., they were mastering age-appropriate developmental tasks, developing significant interpersonal skills, accomplishing academic goals (p. 203)

The fathers from the families rated as optimal were more inclined to focus on interpersonal vocational satisfactions, and to be more directly supportive of their wives.

The Timberlawn team noted in relation to these observations that a whole-family or "systems" assessment tended to emphasize the strengths of "healthy families" whereas individually-based assessments indicated what problems were present in "healthy families" (p. 204).

Finally, the Timberlawn team reiterated that the most healthy families participating in their research were distinguished from adequate and patient-containing families on many variables rather than "a single thread" (p. 206). Though the frequency of "adequately functioning" families was higher in their sample, the Timberlawn team concluded that "we saw this group of families as an unusual, but not necessarily rare, group of families. Perhaps most of all, these optimal families did us the service of revealing a model of what is possible in family relationships" (p. 216).

C. Olson and McCubbin and Associates

A third major contribution to "healthy or normal family" research has been made recently by David Olson and Hamilton McCubbin's research team from the University of Minnesota. An account of Olson and McCubbin's research is presented in their book, *Families: What Makes Them Work* (1983).

Olson and McCubbin studied "normal families" in all stages of family development—from early marriage to retirement—and structured their study around five major theoretical dimensions: 1) family types, 2) family resources, 3) family stress and change, 4) family coping, and 5) family satisfaction (p. 14). Olson and McCubbin stated that "these five dimensions provide the theoretical base for this study; the major linking dimension is family types based on the Circumplex Model. However, all these dimensions can independently be related to each other to provide a more comprehensive picture of these marriage and family systems" (pp. 14–15).

A brief description of the "Circumplex Model" seems warranted by the importance Olson and McCubbin attribute to it in subsequent references, e.g., "the Circumplex Model provides the basic foundation and underlying theme for this entire book. It is used as the dependent variable in much of the analysis" (p. 81; also p. 16). In a seminal (1979) article on the "Circumplex Model of Marital and Family Systems," Olson, Sprenkle, and Russell reported that the Circumplex Model developed over a period of three years from their attempt to integrate a multitude of concepts being used to describe the dynamics of marital and family relationships (p. 5). In their "Circumplex II" article, Olson, Russell, and Sprenkle (1980) elaborated on the nature of the more than fifty concepts they sought to integrate within the Circumplex Model: "While some of these concepts have been used for decades (power and roles, for instance), many of the concepts have been developed recently by individuals observing problem families who had a general systems perspective (pseudo-mutuality, double-binds)" (p. 130). Analysis of these concepts by means of "inductive conceptual clustering" supported Olson, Sprenkle, and Russell's original (1979) designation of "cohesion" and "adaptability" as two primary dimensions underlying marital and family interaction.

After developing their circumplex model integrating family cohesion and adaptability, Olson, Sprenkle, and Russell (1979) discovered that similar integrative efforts had been made by family sociologists in the 1930's and 1940's (p. 14)—Angell's

The Family Encounters the Depression (1936) and Hill's *Families Under Stress* (1949). In 1983, Olson and McCubbin refer to two other sociological studies that also prefigured their integration of family cohesion and family adaptability (p. 93)—Cavan and Ranck's *The Family and the Depression* (1938) and Koos' *Families in Trouble* (1946). Communication was incorporated into the Circumplex model as a third dimension which facilitated cohesion and adaptability by Olson, Sprenkle, and Russell in their (1980) "Circumplex II" paper. The major emphasis in applying the Circumplex Model has been towards clinical treatment of couples and families (Olson, Sprenkle, and Russell, 1979, 1980; Russell, 1979; Sprenkle, 1978; Olson and McCubbin, 1982; and Olson, Sprenkle, and Russell, 1983).

A key purpose of Olson and McCubbin's (1983) research was to describe the characteristics of "normal families" at all stages of family development (p. 18). Olson and McCubbin argued that

> *'normal' families have primarily been used as control groups and have not been the focus of research in their own right. As a result, we know a great deal about the characteristics of problem families and can only assume that normal families are simply lacking those characteristics. What we do not know are the positive aspects of families that help them cope and deal effectively with stress over the life cycle* (p. 19).

Stages in family development or the family life cycle were distinguished by three criteria: age of the oldest child, amount of transition or change required in response to changing developmental needs of the family members, and changes in family goal orientation and direction (p. 21). The seven stages of family development used in Olson and McCubbin's 1983 research were (from p. 22):

Stage 1—Young Couples Without Children
Stage 2—Childbearing Families and Families with Children in the Preschool Years
Stage 3—Families with School-Age Children
Stage 4—Families with Adolescents in the Home
Stage 5—Launching Families (adolescents leaving home)
Stage 6—Empty Nest Families (children are absent from the home)
Stage 7—Families in Retirement

A research sample of 1140 "normal families" fulfilled a sample goal of obtaining at least 100 families in all stages of the family life cycle and approximately 200 families in the adolescent stages (Stages 4 and 5) (p. 23). Olson and McCubbin's team obtained their "normal family" sample through the cooperation of the research department "of a large fraternal organization with a well-developed system of branch offices serving families around the country" (p. 269). When the organization's list of families was categorized according to the seven family life cycle stages, a stratified random sample was drawn (p. 269). Final selection of the research sample required "membership in an intact family" a requirement inclusive of reconstituted families and previously divorced adults (p. 35).

Olson and McCubbin point out several characteristics of their large "normal family" sample. The 1140 families in the sample were represented by a total of 2692 individual family members—1140 married couples or 2280 husbands and wives, and 412 adolescents (p. 23). Length of marriage for couples in the sample ranged from six months to 61 years. Husbands' age ranged from 20–85 years and wives' age ranged from 19–84 years. There was an average of three children per family. Religious preference of the families in the sample was predominantly "Lutheran (husbands, 92 percent; wives, 94 percent; adolescents, 88 percent)" (p. 29). Concerning place of residence, 27 percent of the sample lived on a farm or in a rural area, 48 percent lived in small towns or cities, and 24 percent lived in large cities (p. 29). The sample largely represented the middle and upper-middle class of American society, since "slightly more than 5 percent of the sample reported an income of more than $50,000, and less than 2 percent reported no income or income less than $5,000" (p. 26).

Olson and McCubbin implemented a cross-sectional research design to study their sample of "normal families" distributed throughout all stages of the family life cycle. Longitudinal research on these families was considered beyond the scope of the study "given the 45 to 50-year span of the average family life cycle (p. 36). Thus, Olson and McCubbin explain that

> *while the cross-sectional approach does not allow for an assessment of changes from stage to stage, it does provide the opportunity to examine differences between families at various stages of the family life cycle. What remains open to question with this approach is which differences are due to family life-cycle stage differences and which are due to the social-historical context within each group of subjects or age cohort has lived* (p. 36).

Data was collected from the 1140 families (2280 husbands and wives, 412 adolescents) by means of a self-report survey instrument that incorporated twelve research scales. The survey focused on five major theoretical variables—types of families, family

resources (or marital family strengths), family stress and change, family coping strategies, and marital and family satisfaction (p. 37). All research scales except three were chief-authored by Olson or McCubbin; unless otherwise noted, the scales are presented in the appendix to Olson and McCubbin (1983) and further description can be found in *Family Inventories* (1982). The extensive content of Olson and McCubbin's (1983) instrument is summarized below (from p. 38) by theoretical variable and research scale:

Types of Families

- "Family Adaptability and Cohesion Evaluation Scales (FACES II)" measures family adaptability and cohesion as based on the Circumplex Model.

Family Resources (or Marital and Family Strengths)

- "Family Strengths" measures family pride (loyalty, optimism, and trust in one's family) and family accord (feeling able to accomplish tasks, deal with problems, and get along well together).
- "Parent-Adolescent Communication" measures openness and problems in family communication.
- "Marital Strengths (ENRICH) measures conventionality, personality issues, marital communication, conflict resolution, financial management, leisure activities, sexual relationship, children and marriage, family and friends, equalitarian roles, religious orientation.
- "Congregational Activities Scales" is an instrument developed by Strommen, Brekke, Underwager, and Johnson (1972).

Family Stress and Change

- "Family Life Events and Change (FILE)" measures the impact of strains and stressors categorized as intrafamily, marital, pregnancy and childbearing, finance and business, work, illness and family care, losses, transitions, legal and is based on Hill's (1958) "ABC-X Model" and McCubbin and Patterson's "Double ABC-X Model" of family stress.
- "Adolescent-Family Stress (A-FILE)" assesses impact of developmental transitions, sexuality, losses, responsibility and strains, substance use, legal conflicts; this intrument was developed from the University of Minnesota Family Stress and Coping Project.

Family Coping Strategies

- "Family Coping (F-COPES)" measures degree of reframing, passive appraisal, acquiring social support, mobilizing to acquire/accept help, seeking spiritual support; this instrument was "initially designed to integrate family resources and the meaning perception factors identified in family stress theory" (p. 141).
- "Personal Health Practices Scale" is an instrument developed by Belloc and Breslow (1972).

Marital and Family Satisfaction

- Items on marital satisfaction from "(ENRICH)."
- "Locke-Wallace Marital Adjustment Scale" developed by Locke and Wallace (1959).
- "Family Satisfaction" assesses family members' satisfaction with their family as a whole; items were derived from areas covered by the Circumplex Model.
- "Quality of Life" measures individuals' subjective sense of well-being in areas of life experience including marriage and family life, friends, health, home, education, time, employment, religion, mass media, financial well-being, and neighborhood and community.

Findings from Olson and McCubbin's (1983) "normal family" research were presented in two forms of analysis: descriptive analyses of "normal family" data on types of families, family resources, family stress and change, family coping strategies, marital and family satisfaction; predictive analyses of "normal family" sample revealed a great deal of diversity among "normal families" across stages of the family life cycle.

1. Descriptive Analysis

a. Marital and Family Types

The distribution of family types (balanced, mid-range, extreme) within a particular family life cycle stage did not significantly differ from one stage to another; both individual and couple scores supported this finding on family types in "normal families" (pp. 86–89).

Comparisons of husbands and wives' perceptions on the specific variables of family cohesion and adaptability, however, differed significantly in every family developmental stage except at the launching stage (Stage 5)—wives rated family adaptability and cohesion higher than their husbands.

For couples as a unit, those couples in the first three stages of the family life cycle reported the highest family cohesion, couples in the last two stages scored next highest on family cohesion, and adolescent and launcing stage couples reported the lowest family cohesion. On the adaptability variable, couples without children at home reported the highest family adaptability (rank ordered as Stage 1, 7, 6), couples with children through age 12 scored next highest on

family adaptability, and couples with adolescents at home and leaving home (Stage 4, 5) rated their family adaptability the lowest.

Adolescents reported lower family cohesion and adaptability than either of their parents.

b. Family Resources (or Marital and Family Strengths)

"Family Strengths" scores differed significantly between family life cycle stages, between husbands and wives, and between parents and adolescents. Husbands and wives appeared quite discrepant in their perceptions of family strengths in the first five stages of the family life cycle; empty nest and retirement couples reported more congruent levels of family strengths. Couples and individual family members in the adolescent and launching stages of the family life cycle reported the lowest levels of family strengths; adolescents perceived fewer family strengths than their parents. These stage and sex differences on family strengths were accounted for by measures of "family pride" rather than "family accord."

The "Marital Strengths (ENRICH)" inventory revealed several important content areas that differed for couples and individual husbands and wives across the family life cycle. On "personality issues" (adjustment to and satisfaction with partner's personality), "older couples (Stages 4–7) showed an increasing willingness to rate their spouse's personal behavior favorably. This was a steady upwards trend with no significant differences between husbands and wives" (p. 104; Fig. 6.2, p. 101). Older couples also were significantly more satisfied with family and friends, were more religious, and preferred more traditional husband-wife roles and areas of responsibility than younger couples.

. . . those couples in the first three stages of the family life cycle reported the highest family cohesion, couples in the last two stages scored the next highest on family cohesion, and adolescent and launching stage couples reported the lowest family cohesion.

Individual husband and wife scores differed significantly in some areas of marital strengths. Husbands and wives presented congruent perceptions of marital communication satisfaction in only one stage (Stage 2); husbands in Stages 3–7 reported significantly greater communication satisfaction than their wives, whereas only wives in Stage 1 rated communication satisfaction higher than their husbands. Wives were also more comfortable with family and friends than husbands and more traditional in their view of religion.

The "Congregational Activities Scale" showed that couples in family development Stages 3–7 participated significantly more in church activities than couples in Stages 1–2 (Fig. 6.5, p. 109). Adolescents were much less involved in church activities than their parents and adolescents in launching stage families (Stage 5) reported significantly less participation in church activities than adolescents living at home (Stage 4).

The specific stressor described as "increase in the number of chores that do not get done" was one of the top ten stressors for families in every stage of family development; for families with children at home (Stages 2–4), this stressor was one of the top three reported.

"Parent-Adolescent Communication" scores (individual or family) indicated that "both parents rated these interactions as significantly more open and less problematical than was reported by their adolescents" (p. 224; Fig. 12.1, p. 223). Mothers and adolescents were found to share a significantly greater degree of open communication than fathers and adolescents.

c. Family Stress and Change

Analysis of data gathered on the "FILE" instrument "focused on the clusters of stressors and strains most characteristic of each stage of the family life cycle and on clusters that were consistently mentioned across all stages of the family life cycle" (p. 121). Tables 7.5–7.11, pp. 124–130, record empirical data on family stress and change for the seven stages of family development.

Olson and McCubbin's (1983) data clearly showed that "normal families," regardless of developmental stage, experienced a great many stressors and strains in common. Reports of increases in general "Intrafamily," "Financial," and "Work-Family

"Transitions" strains over the past year characterized every stage of the family life cycle. While "Losses" (through death) was a major strain only for Stage 6 and 7 families, "Illness and Family [Health] Care" was a major strain for families in five stages—Stages 1–2, 5–7. The specific stressor described as "increase in the number of chores that do not get done" was one of the top ten stressors for families in every stage of family development; for families with children at home (Stages 2–4), this stressor was one of the top three reported. For all families with children at home or leaving (Stages 2–5), the specific stressor termed as "increase in the amount of 'outside' activities in which the children are involved" was found to be one of their top five stressors; families with school-age and adolescent children at home reported this stressor as their number one stressor.

Some differences between family life cycle stages were clarified by summarizing major stressors and strains experienced by families in the past year. Stage 1 Young Couples without Children reported that seven of their ten major stressors belonged to the categories of "Financial" and "Work-Family" strains. A strain unique to Stage 2 Childbearing Families was, not surprisingly, "Pregnancy and Childbearing." Stage 3 Families with School-Age Children had to deal with a major "increase in conflict among children."

Families in the last five stages utilized spiritual support significantly more than families in the first two stages. Wives were found to use spiritual support more than their husbands; also, wives in Stages 6 and 7 used spiritual support more than wives in earlier stages.

Stage 4 Families with Adolescents indicated that six of their 10 most common stressors (rank ordered 3–8) were "Financial." Stage 5 Launching Families were marked by "Transition In and Out" strains related to children leaving home and/or beginning college. Stage 6 Empty Nest Families reported a major increase in "Marital" strains. Stage 7 Retirement Families uniquely dealt with the stress of "a member retired from work." The many other stressors reported were common to families in at least two or more stages.

d. Family Coping Strategies

Olson and McCubbin (1983) evaluated the use of five coping strategies used by "normal families" to deal with stressful life events. The use of two internal or intrafamily coping strategies were assessed—reframing, a coping strategy referring to the "ability to define the stressor events as a challenge that can be overcome" (p. 14), and passive appraisal, a coping strategy whereby a stressor event is defined "as something that will take care of itself over time" (p. 141). There were no significant differences between families in the seven family life cycle stages on the use of reframing as a coping strategy. Couples in all stages used reframing more often than passive appraisal and "the average score suggests that parents utilize this strategy more often than other strategies assessed in this inventory" (p. 144). When passive appraisal was used, significant differences were found between families in the early stages of family development (Stages 1–3) and the later stages (Stages 6–7)—early stage families used passive appraisal significantly less often than later stage families. Wives differed from husbands only by tending to use reframing less during the launching period and more during the retirement period. Adolescents, in contrast to their parents, tended to use internal coping strategies that were more passive than active.

Three external coping strategies were assessed by Olson and McCubbin (1983). Spiritual support, seeking advice from ministers, participating in church activities, attending church services, and having faith in God, was "considered important by both husbands and wives throughout the family life cycle" (p. 148). Families in the last five stages utilized spiritual support significantly more than families in the first two stages. Wives were found to use spiritual support more than their husbands; also, wives in Stages 6 and 7 used spiritual support more than wives in earlier stages.

Reports on social support coping strategies, (from relatives, neighbors, friends) showed some distinct contrasts both between couples in different stages of family development and between husbands and wives. Stage 1 couples without children used significantly more social support than Stage 4 and 5 couples with adolescents at home or leaving home. Only Stage 1 and 7 husbands rated social support as an important strategy for coping with stress whereas "wives appear to value and use social support more than husbands do across all seven stages. Social support is particularly important for wives at Stage 3 (Families with School-Age Children) and Stages 6 and 7 (Empty Nest and Retirement)" (p. 150).

Formal supports, community agencies and professionals were used less than other external

coping strategies. Families in the last two stages were found to use formal supports more frequently than families in the first five stages. At all stages of the family life cycle, wives used formal support more often than husbands.

Adolescents' choice of external coping strategies was similar to their parents only on the use of social supports—and female adolescents used social support more frequently than other members of their families. Adolescents were found to use spiritual and formal supports to a significantly lesser degree than either of their parents when experiencing stress.

"Personal Health Behaviors," assessed by Olson and McCubbin (1983) under the theoretical variable of family coping strategies, showed significant differences between individual family members: "Wives had significantly higher health practices scores than did husbands, and adolescents had significantly better health practices than their parents did" (p. 167). Husbands and wives in later Stages 5–7 reported more similar health practices than husbands and wives in earlier Stages 1–4.

. . . the more satisfied couples tend to assess their families as more cohesive and more adaptable.

e. Marital and Family Satisfaction

Olson and McCubbin (1983) sought data on individual's perceptions of three interrelated areas of satisfaction: marital satisfaction, family satisfaction, and overall quality of life satisfaction. Statistical correlation analysis of the three areas of satisfaction showed that "family" and "marital" satisfaction overlapped a great deal with "quality of life" satisfaction as a whole, and that "family" satisfaction accounted for even more of "life" satisfaction than did "marital" satisfaction.

Data on marital satisfaction from Olson and McCubbin's (1983) "normal families" supported previous research indicating "a decline in satisfaction following the birth of the first child and the subsequent rise in satisfaction as the children are launched from the nest" (p. 178). Couples whose children had left home (Stages 6–7) reported significantly higher family as well as marital satisfaction than couples whose children were at home or leaving home. Quality of life satisfaction scores, however, showed a gradual increase across stages of family development. The lowest scores on all three types of satisfaction were found on Stage 4 husbands and fathers of adolescents at home and Stage 5 wives and mothers of adolescents leaving home.

Olson and McCubbin (1983) also analyzed the relation between satisfaction and other areas of family life. When satisfaction was related to the Circumplex Model, it was found that the specific dimensions of family adaptability and family cohesion were strongly related to satisfaction—"Table 10.2 (p. 184) indicates that the more satisfied couples tend to assess their families as more cohesive and more adaptable. The findings hold true for individuals and for couples both across all stages and within each stage" (p. 181). Also, it was found that families reporting higher levels of satisfaction also reported lower levels of stress. Finally, the families highest in satisfaction (upper one-third) were distinguished from families lowest in satisfaction (lower one-third) by scoring higher on measures of family resources (including strengths and coping strategies); these family resources are presented in Table 10.3 and listed below.

Major Resources of Highly Satisfied "Normal Families"

Family Resources	Marital Resources
Cohesion	Conventionality
Adaptability	Communication
Pride	Conflict Resolution
Accord	Personality
Social Support	Leisure
Reframing	Sexual Relationship
Spiritual Support	Children & Marriage
Seeking Help	Family & Friends
Health Practices	Financial Management
	Religious Orientation

2. Predictive Analyses and Findings

For their predictive analysis, Olson and McCubbin (1983) collapsed the seven stages of the family life cycle into four stages so that subgroups identified within each stage would be large enough for an unbiased analysis:

Stage 1—Young Couples without Children
Stage 2—Families with Young Children (through twelve years)
Stage 3—Families with Adolescents (both at home and leaving home)
Stage 4—Older Couples

a. Family Types

Olson and McCubbin (1983) based their predictive analysis of family types on the Circumplex Model which categorizes families, according to their degree of cohesion and adaptability, as either "Balanced," "Mid-Range,"

or "Extreme." "Balanced families are those that have moderate levels of cohesion and adaptability. Overall, Balanced families were hypothesized to have more family strengths that would help them cope with stress more effectively and, therefore, they would end up having higher levels of marital and family satisfaction" (p. 188). In order to simplify analysis, Olson and McCubbin (1983) divided their sample of "normal families" into "Balanced" or "Extreme" family types based on a combination of individual, couple, and family scores.

Olson and McCubbin (1983 emphasize that "one very clear conclusion from this analysis is that there are distinct differences among families at various stages of the life cycle" (p. 192). Variables under the general theoretical dimensions of "marital and family strengths," "family stress," and "marital and family satisfaction" were found to be the most useful in predicting family types. Olson and McCubbin were able to predict family types from these variables with a high degree of accuracy, particularly within stages—e.g., 82 percent or higher for all stages except one that was predicted with 73 percent accuracy (Table 11.1, p. 192).

Differences between families at four different stages of family development were clarified by evaluating what type of family ("Balanced" or "Extreme") worked best at a particular stage. Olson and McCubbin (1983) report that "the decision as to which type functions best was made by looking at scores on family resources [or marital and family strengths], family stress, and family satisfaction" (p. 193).

General predictive findings for Stage 1 families, Young Couples without Children, indicated that "Extreme" type families that were highly cohesive and adaptable had "more positive family resources, lower levels of family stress, and most important, high levels of marital and family satisfaction" (p. 194). Stage 2 Families with Young Children that were most satisfied and least stressed were also "Extreme" type families that were highly cohesive and adaptable. Stage 3 Families with Adolescents that were "Balanced" types (moderately cohesive and adaptable) experienced more satisfaction and less stress than other families with adolescents. Stage 4 families, Older Couples, who reported greatest satisfaction were found to be "Extreme" types that were lower on cohesion and adaptability than less satisfied couples yet "Balanced" type families in this stage experienced the least amount of stress. Concerning their Stage 4 findings, Olson and McCubbin write that "the results from this stage are more puzzling than are those for the other stages and suggest the need for further research" (p. 201).

b. High and Low-Stress Families

Olson and McCubbin's (1983) predictive analysis of high and low-stress families was conducted within the framework of the "Double ABC-X theory of family stress and adjustment), which assumes that the process of managing stress and transitions involves balancing demands with family resources" (p. 203; see McCubbin and Patterson, 1983). Marital and family strengths, coping strategies, and resources were grouped together as "family resources" to simplify analysis. Couple scores on the "Family Inventory of Life Events (FILE)" instrument were used to identify high and low-stress families in four stages of family development (combined from the earlier seven stages). Moderately stressed families (85 percent of the sample) were not included in the analysis.

The first purpose of the analysis was to predict which families were high and low in stress from family resource variables. Olson and McCubbin (1983) obtained 86 percent accuracy in predicting high and low-stress families (Table 12.1, p. 206). The second purpose of the analysis was to identify which family resources were important (in terms of statistical significance) in discriminating between high and low-stress families at different stages of family development. Further use of a stepwise statistical procedure delineated which family resources were most "critical" to families reporting low amounts of stress. Critical and important family resources used by low-stress families in each life cycle stage to deal with the stressors and strains of family life are presented below (from pp. 207–216; Appendix F, pp. 281–283).

Family Resources Characterizing Low-Stress Families

Stage 1 Young Couples without Children

Critical Resources—Family Accord, Financial Management, Communication, Personality Issues (resolved), Leisure Activities, Health Practices

Important Resources—Quality of Life, Family Satisfaction, Marital Satisfaction, Conflict Resolution, Family and Friends

Stage 2 Families with Young Children

Critical Resources—Family Accord, Financial Management, Communication, Family and Friends, Child Orientation, Social Support (not as necessary), Family Satisfaction, Quality of Life

Important Resources—Health Practices, Fatalism

(not used), Congregational Activities (not as involved), Marital Satisfaction, Personality Issues (resolved), Sexual Relationship, Religious Orientation, Leisure Activities, Cohesiveness, Adaptability

Stage 3 Families with Adolescents

Critical Resources—Financial Management, Personality Issues (resolved), Family and Friends, Sexual Relationship, Marital Satisfaction, Quality of Life

Important Resources—Health Practices, Reframing, Fatalism (not used), Family Satisfaction, Communication, Conflict Resolution, Religious Orientation, Child and Marriage, Leisure Activities, Family Accord

Stage 4 Older Couples

Critical Resources—Communication (not an issue), Personality Issues (resolved), Health Practices (not an issue)

Important Resources—Quality of Life, Family Satisfaction (not an issue), Marital Satisfaction (not an issue), Cohesiveness, Adaptability

IV. Professional Commitment to Strong, Healthy Families

Pioneer research on strong, healthy families has served to draw together professionals who are substantially committed to promoting strong families.

Several major publications exemplifying this commitment should be mentioned as reference for those actively involved in developing strong, healthy families—whether personally or professionally, privately or publicly. Two fine translations of pioneer research on strong, healthy families are Nick Stinnett and John DeFrain's *Secrets of Strong Families* (1986) and Jerry Lewis' *How's Your Family: A Guide to Identifying Your Family's Strengths and Weaknesses* (1979). As a complement to research on strong, healthy families, Dolores Curran's popular book, *Traits of a Healthy Family* (1983), is based on results from her survey of 551 professionals in education, churches, healthcare, family counseling, and voluntary organizations concerning what 15 traits (out of 56 listed) they perceived as positive evidence of a healthy family.

In addition to books dealing with the direct application of knowledge of strong, healthy families to everyday life, publications resulting from a number of professional conferences indicate the convergence of practical, theoretical, and policy interests in strong, healthy families. In May 1978, a symposium on Building Family Strengths was held at the University of Nebraska-Lincoln headed by Nick Stinnett. Plenary session speeches and other papers presented at the symposium were subsequently published under the editorship of Stinnett et al. as *Building Family Strengths—Blueprints for Action* (1979). As of May 1986, nine annual symposiums on Building Family Strengths have been held at the University of Nebraska-Lincoln. These symposiums have brought together a diverse group of professionals from many institutional areas of culture; also representatives from both research traditions in strong, healthy family research have contributed to these symposiums (e.g., McCubbin and Patterson, 1981). Proceedings from symposiums 2 through 7 have also been published. *Family Strengths: Positive Models for Family Life* (1980), *Family Strengths 3: Roots of Well-Being* (1981), and *Family Strengths 4: Positive Support Systems* (1982), edited by Stinnett et al. are currently available through the University of Nebraska Press. *Family Strengths 5: Continuity and Diversity* (Rowe et al., 1984), *Family Strengths 6: Enhancement of Interaction* (Williams et al., 1985), and *Family Strengths 7: Vital Connections* (VanZandt et al., 1986) are currently available through the Center for Family Strengths, Department of Human Development and the Family at the University of Nebraska-Lincoln.

Proceedings from the National Leadership Forum on Family Well-Being held June, 1984 were published as *Family Building: Six Qualities of a Strong Family* (1985) under George Rekers' editorship. Participants in the forum addressed three questions: 1) "What qualities make a family strong?," 2) "What can be done in the local community to strengthen families?"

Panel discussions led by Froma Walsh on "normal family processes" at the 1978 and 1979 Annual Meeting of the American Orthopsychiatric Association generated contributions to Walsh's edited volume, *Normal Family Processes* (1982). Sections on theoretical conceptualizations of normal family processes and a review of five research projects then in progress by mental health professionals are found in the first third of this book; the remainder is devoted to integrating literature and clinical observations on temporal, structural, and sociocultural variations which characterize normal families.

Commitment to promoting and understanding strong, healthy families is also shared by those professionals who 1) are concerned with the physical, social, and cultural "ecology" of families, 2) who view families as vital support systems for human beings

within their communities, 3) who interpret the family as a "productive" economic unit—e.g., the key developer of human resources—rather than a mere "consumer" economic unit, and/or 4) recognize families and their members as "active" agents in human history rather than "passive" clay in the mold of outside forces.

This review of pioneer research on strong, healthy families is a mere beginning towards documenting activities relevant to strengthening families—a growing body of professional and popular literature, formal and informal organizations and networks, community activities, and public policy hearings and recommendations. Much remains to be done, theoretically as well as practically, towards recovering positive and vital models of family life in this nation.

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